Carolina Ear, Nose & Throat

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Authorization to Release Health Information

Patient Information:
Name of Patient_____**Date of Birth**_____

Address_____

City, State, Zip_____

Name & address of Covered Entity (Physician, Facility) authorized to release information:

_____

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_____

Forward information to:

_____

_____

PLEASE FORWARD INFORMATION INCLUDING DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD
FROM_____**TO**_____

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization my be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that the revocation is not effective if the information has already been disclosed but will be effective going forward.

_____**Date**_____
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)